

MATHPATH SUMMER PROGRAM 2012 HEALTH FORM

This form has 3 pages. The parent or guardian must sign several places on page 2. The student's doctor must sign on page 3. The information and signatures are necessary in the event your child needs medical treatment at MathPath. You or your physician should attach extra sheets if you need more space. Submission of this completed form by a parent or guardian, by *May 31, 2012*, is required before a student can attend. *Please do not staple these pages together or print them out 2-sided.*

PAGE 1: CONTACT AND INSURANCE INFORMATION

STUDENT INFORMATION

Student's Name _____ Gender _____
Permanent Address _____ Date of Birth _____
City/State/Zip _____ Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:	Backup contact (relative or friend):
Name _____	Name _____
Relation to student _____	Relation to student _____
Daytime Phone _____	Daytime Phone _____
Evening Phone _____	Evening Phone _____

INSURANCE POLICY INFORMATION for a policy valid in Massachusetts, at least Hampshire and Hampden Counties. (MathPath will be located in Hampshire County, but on the border between them.) With this form **please send two copies of a scan of both sides of the insurance card that proves you child is covered.** If you are not able to send these scans, then not only must you fill out this section, but also you child *must* bring that card to camp, and carry it on his/her person at all times.

Rest of this page to be filled out only if you cannot provide scans of the insurance card; we strongly prefer the scans.

Policy Holder's (P.H.) Name _____ P.H. Date of Birth _____
P.H. Address _____ Relation to Student _____
P.H.'s Employer _____
Insurance Company Name _____
Insurance Company Address _____
Policy # _____ Plan # _____

Insurance Co. phone number for Customer Service _____ If the Insurer has different numbers for out-of-area coverage or precertification, please give those here:

PAGE 2: MEDICAL CONDITIONS AND TREATMENT PERMISSIONS

Student's Name: _____

DOES THE STUDENT CURRENTLY HAVE ANY OF THE FOLLOWING? (if yes, please describe)

Drug allergies: _____

Food allergies: _____

Seasonal allergies: _____

Environmental allergies: _____

Allergies to insect bites: _____

Special dietary needs: _____

Asthma: _____

Frequent headaches: _____

Dizziness or seizures: _____

Other health problems, including ADD and ADHD: _____

Limitations of Activities: _____

Medications the student is currently taking, dosages and frequencies:

MEDICATIONS CONSENT. The default is that students will deposit their medications with our nurse, and will come each day to the nurse's station to be given those medications. If you child is taking medications, you may choose to have him/her self-medicate with your signed consent below.

Nurse will administer Student will self-administer

Parent or guardian signature _____ Date _____

COMMON REMEDIES CONSENT. By your signature below, you give permission for the nurse to administer the following. *Please cross out any you do not wish to allow.*

Ibuprofen, Tylenol, Benadryl, cough drops, zyrtec, midol for cramps, pepto bismol for stomach upset.

Parent or guardian signature _____ Date _____

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named student, authorize MathPath staff to seek medical diagnosis and treatment for the student as they see necessary. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide MathPath staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named student. I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, MathPath staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that MathPath staff will notify me or my designee as soon as possible of any and all diagnoses and treatments.

Legal Guardian's Signature

Print Name

Date

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PAGE 3: MEDICAL HISTORY AND PHYSICIAN'S AUTHORIZATION

Student's Name: _____

MEDICAL HISTORY

IMMUNIZATION DATES:

Date of last medical check-up (should be

Measles _____

after June 24, 2011): _____

Mumps _____

Reasons for any hospitalizations in the past 5 years:

Rubella _____

OR MMR _____

Last Tetanus _____

(DPT, TT or TD) _____

Polio Series _____

PHYSICIAN'S SECTION please print

Dear Physician: The typical choice of MathPath physical activities are, on campus: soccer, basketball, tennis, pickleball, swimming, Frisbee; off-campus: hiking, cycling, and if available, whitewater rafting, rock climbing, canoeing and kayaking.

Physician's Name: _____

Address: _____

City/State/Zip _____ Telephone _____

I have examined the above named student and found that s/he is able to participate in all activities of MathPath. (If exceptions, cross out entries above or add a statement below.)

Physician's Signature

Date